

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Randolph
Township Sugar Creek
or
Village ~~High Bridge~~
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 736 File No. 40283
Primary Registration District No. 5970 Registered No. 203

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ola May Lucas

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH April 21, 1890
(Month) (Day) (Year)
AGE 22 yrs. 8 mos. 3 ds.
If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) None

BIRTHPLACE
(City or town, State or foreign country) Randolph Co Mo

NAME OF FATHER W C Jones

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Macon Co Mo

MAIDEN NAME OF MOTHER Anna L Thompson

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Macon Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J J Lucas
(ADDRESS) Moberly Mo

Filed 12/26 1912 W. B. Lucas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 24 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1912, to Dec 24, 1912, that I last saw her alive on Dec 24, 1912, and that death occurred, on the date stated above, at 6:20 a.m.

The CAUSE OF DEATH* was as follows:
Tubercular Peritonitis

107 A (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. P. Lowles M. D.
1912 (Address) Moberly Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted If not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Humsville DATE OF BURIAL 25-3 1912

UNDERTAKER A. S. Chandler ADDRESS _____

encephalitis meningitis; Dysentery; Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, peritonaeum, etc.; Carcinoma, Sarcoma, etc. of

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File No. _____
Registered No. _____
St. _____ Ward _____
If death occurred in hospital or in home, give its NAME and street and number _____

LOCAL CERTIFICATE OF DEATH
(Month) _____ (Day) _____
CERTIFY, that I attended deceased _____, 191____, to _____, I _____, I _____, arrived, on the date stated above, at _____
DEATH* was as follows:

(Duration) _____ yrs. _____ mos.
(Duration) _____ yrs. _____ mos.
(Address) _____
Causes of Death or in deaths from Violent Causes, whether Accidental, Suicidal, or Homicidal.
DE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS)
mos. _____ ds. State _____ yrs. _____ mos.
attracted _____
th?

DATE OF BURIAL _____
ADDRESS _____

line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

"*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("Congenital," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Written on this Supplementary Certificate